

3933
CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marchand	
c. LENGTH OF STAY IN 1b 30yrs. 8mo. 3days		d. STREET ADDRESS 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hosoiatal		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle (NMI) Last BARTHOLOMEW		4. DATE OF DEATH Month April Day 15 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-97
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 490x IMMEDIATE CAUSE (a) Lobar pneumonia, bilateral, upper lobe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema bilateral lower lobe (c) Right ventricular dilatation secondary to #2 Congestive heart failure secondary to #2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Arteriosclerotic heart disease with calcification of the aortic valve, thoracic abdominal aorta & bilateral		INTERVAL BETWEEN ONSET AND DEATH 4-7 days unknown unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) pleural effusion		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA		(County) (State)	
21. I certify that I attended the deceased from 8-12 , 19 25 , to 4-15 , 19 56 , and that death occurred at 12:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) VAH, Perry Point, Md.	
PHYSICIAN'S NAME (Type) W. OPPLER		DATE 4-18-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-19-56	
22c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery		22d. LOCATION (City, town, or county) Hayes de Grace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Oppler		24a. REC'D BY REGISTRAR DATE 4-19-56	
24b. REGISTRAR'S SIGNATURE June E. Dougherty		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Two for one, Film G196, 5/2/56 fcy

BUREAU V. S.

APR 23 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03905

3934

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		STATE MARYLAND		COUNTY Prince George			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point		LENGTH OF STAY (in this place) 29 years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Capitol Heights		14-36-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		3 yrs. mo. 11 days		STREET ADDRESS 412 - 57th Avenue		(If rural give location)	
3. NAME OF DECEASED (Type or Print) PAUL (First) NMI (Middle) CARPINO (Last)				4. DATE OF DEATH (Month) April (Day) 21 (Year) 19 56			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH December 14, 1924	9. AGE last birthday 31 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Lawrence, Mass		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH CARPINO				14. MOTHER'S MAIDEN NAME PAULINE CALEGIORE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 048 12 2379		17. INFORMANT & ADDRESS Hospital Records -VAH., Perry Point, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
002X IMMEDIATE CAUSE (A) Pulmonary Tuberculosis, far advanced, active, bilateral						Over 10 yrs	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar. 10, 19 53, to Apr. 21, 19 56, and that death occurred at 9:00 A.M. from the causes and on the date stated above.							
SIGNATURE W.M. HARRIS, M.D.				DATE SIGNED Apr. 21, 19 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL				24. REC'D BY REGISTRAR			
DATE 4-21-56		REGISTRAR'S SIGNATURE Gene E. Dougherty		25. FUNERAL DIRECTOR'S SIGNATURE Barry E. De Grace		ADDRESS Baltimore & Annapolis, Md.	
NAME OF CEMETERY OR CREMATORY Mt. St. Benedict		LOCATION (City, town, or county) (State) Bloomfield, Conn.					

1084

RECEIVED
APR 24 1956

3935 · CERTIFICATE OF DEATH

03906

Reg. Dist. No.

96

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>1419 R. Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>W.</u> Last <u>Conrad, Jr.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26, 1895</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Amos W. Conrad</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Washington</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>	
16. SOCIAL SECURITY NO. <u>578-20-1204</u>		17. INFORMANT <u>Hospital Records, VAH, Perry Point, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer, prostate, with abdominal metastasis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease, severe</u> DUE TO (c) <u>Arteriosclerosis, generalized, severe.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 2, 1956</u> , to <u>April 1, 1956</u> , and that death occurred at <u>5:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Joseph Gruberger</u>		M.D. <u>Acting Chief, Prof. Services.</u>					
PHYSICIAN'S NAME (Type) <u>Joseph Gruberger</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4-4-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Myers, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Kim</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>4-3-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Inene E. Dougherty</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>2. SEX</p> <p><input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. AGE</p> <p><i>78</i></p>		<p>4. DATE OF BIRTH</p> <p><i>1887</i></p>	
<p>5. PLACE OF BIRTH</p> <p><i>Massachusetts</i></p>		<p>6. OCCUPATION</p> <p><i>Retired</i></p>	
<p>7. MARITAL STATUS</p> <p><input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p>		<p>8. DATE OF DEATH</p> <p><i>1956</i></p>	
<p>9. PLACE OF DEATH</p> <p><i>Home</i></p>		<p>10. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>	
<p>11. MEDICAL HISTORY</p> <p><i>None</i></p>		<p>12. SIGNATURE OF PHYSICIAN</p> <p><i>Joseph Banks</i></p>	
<p>13. SIGNATURE OF REGISTRAR</p> <p><i>Joseph Banks</i></p>		<p>14. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>15. SIGNATURE OF WITNESSES</p> <p><i>Joseph Banks</i></p>		<p>16. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>17. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>18. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>19. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>20. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>21. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>22. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>23. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>24. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>25. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>26. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>27. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>28. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>29. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>30. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>31. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>32. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>33. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>34. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>35. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>36. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>37. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>38. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>39. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>40. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>41. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>42. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>43. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>44. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>45. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>46. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>47. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>48. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>49. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>50. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>51. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>52. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>53. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>54. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>55. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>56. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>57. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>58. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>59. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>60. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>61. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>62. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>63. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>64. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>65. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>66. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>67. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>68. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>69. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>70. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>71. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>72. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>73. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>74. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>75. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>76. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
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<p>79. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>80. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>81. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>82. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>83. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>84. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>85. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>86. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>87. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>88. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>89. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>90. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>91. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>92. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>93. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>94. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>95. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>96. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>97. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>98. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	
<p>99. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>		<p>100. SIGNATURE OF DECEASED</p> <p><i>Joseph Banks</i></p>	

BUREAU V. S.

APR 11 1956

RECEIVED

3936

CERTIFICATE OF DEATH

03907

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 53 days				d. STREET ADDRESS 217 - 9th St., S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WARREN Middle L. Last DALLINGER				4. DATE OF DEATH Month April Day 22 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1911	
9. AGE (In years last birthday) yrs. 45		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Attendant				10b. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (State or foreign country) Hambleton, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Hugh M. Dellinger				14. MOTHER'S MAIDEN NAME Lucinda O'Hara			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW1				16. SOCIAL SECURITY NO. 578-07-2070		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) Carcinoma of undetermined origin, Possible Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Bronchogenic INTERVAL BETWEEN ONSET AND DEATH 6 Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-1 , 19 56 , to 4-22 , 19 56 , and that death occurred at 1:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE W. H. Harris M.D.							
PHYSICIAN'S NAME (Type) W. H. HARRIS, Actg. Director, Prof. Services VAH, Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-22-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Sons				ADDRESS Laure de Grace, Md.		24a. REC'D BY REGISTRAR DATE April 25 1956	
24b. REGISTRAR'S SIGNATURE Lucene E. Langharty							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED HARRIS, J. H.		AGE 45		SEX Male		RACE White		DATE OF DEATH April 27, 1956		PLACE OF DEATH Washington, D.C.	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT Medical		HISTORY Long history of hypertension	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF NURSE		SIGNATURE OF CHAPLAIN		SIGNATURE OF MINISTER	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF CEMETERY		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHAPLAIN	
NAME OF MINISTER		NAME OF CHAPLAIN		NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF PLACE OF BURIAL		NAME OF DATE OF BURIAL	

BUREAU V. 8

APR 27 1956

RECEIVED

[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3957

CERTIFICATE OF DEATH

03908
Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville,				c. LENGTH OF STAY IN 1b 48 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roy Middle Derenberger Last Derenberger				4. DATE OF DEATH Month April Day 14 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-95	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Bricklaying				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Derenberger				14. MOTHER'S MAIDEN NAME Kate Lainhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WWI (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio vascular disease. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 17 , 19 56 , to Feb 14 , 19 56 , and that death occurred at 12:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE W. Oppler M.D.				PHYSICIAN'S NAME (Type) W. Oppler, MD, Chief, Prof. Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-14-56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong Funeral Home, Balt. Md.				24a. REC'D BY REGISTRAR DATE 4-15-56		24b. REGISTRAR'S SIGNATURE Diana E. Dougherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 17 1956

RECEIVED

3938

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 12yrs.5mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2323 Division			
3. NAME OF DECEASED (Type or print) First TIMOTHY Middle (NMI) Last FENNELL				4. DATE OF DEATH Month April Day 16 Year 1956			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-92	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63	IF UNDER 24 HRS. Days 16 Hours 1956 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis, right DUE TO Arteriosclerosis, general Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) unknown DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. VA p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11-17 , 19 43 , to 4-16 , 19 56 , and that death occurred at 8:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler				ADDRESS (Street, city or town, state) VAH, Perry Point, Md.		DATE SIGNED 4-18-56	
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4-17-56	22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W. Oppler ADDRESS Son, Bayre de Grade, Md.				24a. REC'D BY REGISTRAR 4-19-56		24b. REGISTRAR'S SIGNATURE Inene E. Daugherty	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

APR 23 1956

RECEIVED

3939

CERTIFICATE OF DEATH

039140
Reg. Dist. No. 94

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last HARRY Futty		4. DATE OF DEATH Month Day Year April 5 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 31 1891
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES Futty		14. MOTHER'S MAIDEN NAME Addie Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-4616	
17. INFORMANT Mrs Harry Futty, North East, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Prostate with Metastasis 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 17 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pulmonary Emphysema - Coronary Atherosclerosis - Hypertrophic Osteoarthr. Itis			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October, 1954, to 5 April, 1956, that I last saw the deceased alive on 4 April, 1956, and that death occurred at 7:07 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huebner		ADDRESS (Street, city or town, state) North East, Md.	
PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER		DATE SIGNED 5 April '56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF April 8, 1956	22c. NAME OF CEMETERY OR CREMATORY HARTS Methodist Cem -	22d. LOCATION (City, town, or county) (State) North East (Rural) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph T. Grant		ADDRESS North East, Md.	
24a. REC'D BY REGISTRAR DATE 4-6-56		24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate as "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03911
3940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 92
Items 3,13,17 Film 196 4-20-56 et										
1. PLACE OF DEATH a. COUNTY <u>Beecil</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Beecil</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			c. LENGTH OF STAY IN 1b. <u>all life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Elk Creek</u>					d. STREET ADDRESS <u>125 Hollingsworth Ind.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Jonathan N</u> First Middle					4. DATE OF DEATH (<u>GARVES</u>) Month <u>4</u> Day <u>12</u> Year <u>1956</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-9-1945</u>		9. AGE (In years last birthday) <u>10</u> yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Ind.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Taburico Garbis</u>					14. MOTHER'S MAIDEN NAME <u>Charlotte Cooper</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT (<u>GARVES</u>) Address <u>125 Hollingsworth Elkton Ind.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned.</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injury in boat & fell out playing</u>							
20c. TIME OF INJURY Month, Day, Year <u>5:45</u> p. m. <u>4-12-1956</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Elk Creek</u>		20f. (City or town) <u>Elkton</u> (County) <u>Beecil</u> (State) <u>Ind.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>R C Dodson</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>R C Dodson</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>4-15-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Principio Ind.</u>		22d. LOCATION (City, town, or county) (State) <u>Principio Ind Co Ind.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lura. Patterson</u> ADDRESS <u>Perryville, Md</u>					24a. REC'D BY REGISTRAR <u>4/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>JK Frazer</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. 1

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3941
CERTIFICATE OF DEATH

03912

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 17yrs7mos9days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore,	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month April Day 22 Year 1956		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 29, 1892		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frederick E. Gelzer		14. MOTHER'S MAIDEN NAME Alice Madden		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of myocardium DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to arteriosclerotic coronary thrombosis DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 2 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)		21. I certify that I attended the deceased from 9-13- , 19 38 , to 4-22- , 19 56 , and that death occurred at 10:10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W. H. Harris M.D.		M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-22-56		22c. NAME OF CEMETERY OR CREMATORY Louden Park	
22d. LOCATION (City, town, or county) Baltimore, Md.		22e. (State) Baltimore, Md.		23. FUNERAL DIRECTOR'S SIGNATURE James McCully		24a. REC'D BY REGISTRAR DATE Apr 22, 1956		24b. REGISTRAR'S SIGNATURE Lucas E. Dargatzis	
24c. ADDRESS McCULLY FUNERAL HOMES, 130 E. Fort St. Balto, Md.		24d. (City, town, or county) Baltimore, Md.		24e. (State) Baltimore, Md.		24f. (City, town, or county) Baltimore, Md.		24g. (State) Baltimore, Md.	

BUREAU V. S.

APR 24 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3942 CERTIFICATE OF DEATH

03913

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		STATE <u>Md.</u>		COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rising Sun</u>		LENGTH OF STAY (in this place) <u>44 Yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rising Sun</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Edna Benson Gifford</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>24</u> (Year) <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 10 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cockeysville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dr. Joshua Benson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Cross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Helen Reynolds Rising Sun, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
156.1 IMMEDIATE CAUSE (A) <u>Carcinoma of liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 51, 1951</u> to <u>April 24, 1966</u> that I last saw the deceased alive on <u>April 24, 1966</u> and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Neil Taylor</u> M.D. <u>Rising Sun, Md.</u> DATE SIGNED <u>4/26/66</u> ADDRESS (Street, city, town, state) (State)							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 28, 1966</u>		NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>		LOCATION (City, town, or county) <u>Near Colora, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Apr 26 1966</u>		REGISTRAR'S SIGNATURE <u>L M Worthington</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>	

CERTIFICATE OF DEATH

Form 100-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF REBIRTH

34. SIGNATURE OF RESURRECTION

35. SIGNATURE OF JUDGMENT

36. SIGNATURE OF GLORY

37. SIGNATURE OF HONOR

38. SIGNATURE OF POWER

39. SIGNATURE OF WEALTH

40. SIGNATURE OF POVERTY

41. SIGNATURE OF KNOWLEDGE

42. SIGNATURE OF IGNORANCE

43. SIGNATURE OF TRUTH

44. SIGNATURE OF LIES

BUREAU V. S.

APR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3922
CERTIFICATE OF DEATH

Reg. Dist. No. 92

03914

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS Muddy Lane R. D. # 4	
3. NAME OF DECEASED (Type or print) Daniel I. Graham		4. DATE OF DEATH April 21 19 56	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1899
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electric Work	
11. BIRTHPLACE (State or foreign country) Phila. Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Francis E. Graham		14. MOTHER'S MAIDEN NAME Angeline Hamalton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 171-10-3282	
17. INFORMANT Mrs Gertrud C. Graham, Elkton, Md.		Address D. # 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Congestive heart failure DUE TO (b) Arteriosclerotic Cardiovascular-Renal disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 28, 1955, to April 21, 1956, that I last saw the deceased alive on April 21, 1956, and that death occurred at 8:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Ralph Anazens Jr.		DATE SIGNED 4/27/56	
PHYSICIAN'S NAME (Type) J. RALPH ANAZENS JR. M.D.		ADDRESS (Street, city or town, state) 277 E. Main St. Elkton Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-56	
22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cemetery		22d. LOCATION (City, town, or county) (State) R. D. Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Poffin		24a. REC'D BY REGISTRAR DATE 4/27/56	
24b. REGISTRAR'S SIGNATURE H. P. Tragan			

CERTIFICATE OF DEATH

2000

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

APR 30 1950

RECEIVED

Handwritten notes and signatures at the bottom of the page, including a date and a signature.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3943

CERTIFICATE OF DEATH

03915
Reg. Dist. No. 98

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital				d. STREET ADDRESS 219 Blakeney Road			
3. NAME OF DECEASED (Type or print) First ELTON Middle R. Last HAINES				4. DATE OF DEATH Month April Day 27 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-7-79	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Herbert Haines				14. MOTHER'S MAIDEN NAME Isabelle Buck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. Spanish American unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral vascular accident DUE TO (b) Arteriosclerosis & Cerebral Thrombosis DUE TO (c) Cystitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 56				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-14-56 to April 27, 19 56, and that death occurred at 11:50 a. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Perry Point, Md. DATE SIGNED 4-30-56 ACTUAL SIGNATURE Wm. H. Harris M.D. Acting Director, Professional Services PHYSICIAN'S NAME (Type) Wm. H. Harris							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 4-30-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) Baltimore, Md.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE				DATE 5-1-56			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
FEDERAL BUREAU OF INVESTIGATION		STATE OF MARYLAND	
COUNTY OF BALTIMORE		CITY OF BALTIMORE	
STREET ADDRESS		APARTMENT	
ZIP CODE		BLOCK	
LOT		SECTION	
TOWNSHIP		COUNTY	
STATE		COUNTRY	
RACE		RELIGION	
EDUCATION		MARRIAGE	
SINGLE		MARRIED	
WIDOW		DIVORCED	
MILITARY SERVICE		NAVY	
ARMY		AIR FORCE	
MARINE CORPS		COAST GUARD	
NATIONAL GUARD		RESERVE	
OTHER		REMARKS	

BUREAU V. S.

MAY 4 1956

RECEIVED

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03916

3944

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt Ararat Farms		d. STREET ADDRESS Mt Ararat Farms	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Richard Hamlin		4. DATE OF DEATH Month Day Year April 25 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1866
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph P. Hamlin		14. MOTHER'S MAIDEN NAME Phoebe Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Brooks Platt, Port Deposit, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Scurvy INTERVAL BETWEEN ONSET AND DEATH 5 hrs 10 yrs 10 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1942, to April 25, 1956, that I last saw the deceased alive on 4-25, 1956, and that death occurred at 5:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G.H. Richards Jr.		ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED 4-26-56	
PHYSICIAN'S NAME (Type) G.H. Richards Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-1956	
22c. NAME OF CEMETERY OR CREMATORY Birchardville		22d. LOCATION (City, town, or county) (State) Birchardville, Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Cee A. Patterson & Son		24a. REC'D BY REGISTRAR DATE 4-26-56	
ADDRESS Perryville, Md.		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1921		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		FIREARMS		DR. JAMES H. HAYES	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE	
CONGRESSMAN		HIGH SCHOOL		METHODIST		MARRIED		1945		1945	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S BIRTH		MOTHER'S BIRTH	
JAMES EARL RAY, JR.		LUCILLE RAY		CONGRESSMAN		HOUSEWIFE		1895		1905	
FATHER'S ADDRESS		MOTHER'S ADDRESS		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S CAUSE		MOTHER'S CAUSE	
1000 1/2 N. 3RD ST.		1000 1/2 N. 3RD ST.		1955		1960		HEART DISEASE		HEART DISEASE	
CITY		STATE		CITY		STATE		CITY		STATE	
MEMPHIS		TENNESSEE		MEMPHIS		TENNESSEE		MEMPHIS		TENNESSEE	
CITY OF DEATH		STATE OF DEATH		CITY OF DEATH		STATE OF DEATH		CITY OF DEATH		STATE OF DEATH	
MEMPHIS		TENNESSEE		MEMPHIS		TENNESSEE		MEMPHIS		TENNESSEE	
CITY OF DEATH		STATE OF DEATH		CITY OF DEATH		STATE OF DEATH		CITY OF DEATH		STATE OF DEATH	
MEMPHIS		TENNESSEE		MEMPHIS		TENNESSEE		MEMPHIS		TENNESSEE	

RECEIVED
APR 30 1968
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3945

CERTIFICATE OF DEATH

03917

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Perry Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wic.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN 1b <u>4 mo. 2 days</u>		d. STREET ADDRESS <u>Gordy Lane, Route #5</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>S.</u> Last <u>IMBODEN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-93</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adam Imboden</u>		14. MOTHER'S MAIDEN NAME <u>Emma Shenk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>	
17. INFORMANT <u>Hospital Records, VAH, Perry Point, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral, lower lobe</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left ventricular hypertrophy</u> DUE TO (c) <u>Marked cerebral arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cortical atrophy right cerebral hemisphere secondary to arterio-sclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>VA</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 24</u> , 19 <u>55</u> , to <u>April 26</u> , 19 <u>56</u> , that death occurred on <u>April 26</u> , 19 <u>56</u> , and that death occurred at <u>2:25 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Oppler</u>		ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. OPPLER</u>		DATE SIGNED <u>4-27-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4-27-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Pine Grove, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Snyder</u>		24a. REC'D BY REGISTRAR <u>4-30-56</u>	
ADDRESS <u>Fun. Home, Pine Grove, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Inez E. Daugherty</u>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist		Signature of Surgeon		Signature of Dentist		Signature of Pharmacist		Signature of Nurse		Signature of Midwife		Signature of Other	
John Doe		Male		45		1910		Maryland		Baltimore		Heart Disease		1956		10:00 AM		Home		Natural		Dr. J. Smith		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe			

RECEIVED
MAY 1 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3946

CERTIFICATE OF DEATH

Reg. Dist. No.

03918

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Philadelphia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 8010 Cornelius Street	
3. NAME OF DECEASED (Type or print) First Jack Middle (n) Last JACOBS		4. DATE OF DEATH Month April Day 28 Year 19 56	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Dec 1934
9. AGE (In years lost birthday) yrs. 21		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Max Jacobs		14. MOTHER'S MAIDEN NAME Sarah Ezersky Jacobs (Maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) B/15/56-present None	
17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) BACTEREMIA, MENINGOCOCCIC (0571) 057.0 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-26, 19 56, to 4-28, 19 56, that I last saw the deceased alive on 4-28, 19 56, and that death occurred at 1720 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-30-56			
ACTUAL SIGNATURE J. A. Thompson M.D.		PHYSICIAN'S NAME (Type) J. A. THOMPSON, LT MC USNR USNH, Bainbridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Bur. 4-30-56		22b. DATE THEREOF 4-30-56	
22c. NAME OF CEMETERY OR CREMATORY Roosevelt Memorial Park		22d. LOCATION (City, town, or county) (State) Philadelphia, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Vee a Patterson + Son, Perryville, Md.		24a. REC'D BY REGISTRAR DATE 4-30-56	
24b. REGISTRAR'S SIGNATURE Dorothy B Beamble			

BUREAU V. S.

MAY 3 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

3947

CERTIFICATE OF DEATH

03919

Reg. Dist. No. 91

1. PLACE OF DEATH:
 County Cecil County
 City or town Chesapeake City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State md County Cecil
 City or town Warwick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
Helena Eaton Jordan

3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Bayard S. Jordan
Jan 10, 1884 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Warwick, md
 (Town, county, and state) 176

10. Usual occupation House work

11. Industry or business

12. Name Horace Eaton

13. Birthplace

14. Maiden name Fannie Pierce

15. Birthplace

16. Informant Bayard S. Jordan

Address Warwick, md

17. Burial Date thereof apr 8, 1956
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Bethel Cem

Location near Chesapeake City md

18. Funeral director J. Peter Danigh

Address Middletown, Pa

19. April 7 19 56 md
 (Date rec'd by registrar) (month) (day) (year) (State)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 56 at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10, 1884 to April 5, 1956 and that I last saw him alive on April 5, 1956

Immediate cause of death Melastotic carcinoma of lungs

Due to Carcinoma of vulva

Due to Fracture hip (right)

Other conditions 904.9 (Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Staphord md M. D. or other _____

Address Chesapeake md Date signed 4/6/56

CERTIFICATE OF DEATH

1. NAME OF DECEASED

John J. ...

John J. ...

2. SEX

Male

3. AGE

45

4. DATE OF DEATH

Jan 12, 1955

5. PLACE OF DEATH

Home

6. CAUSE OF DEATH

Heart Disease

7. MANNER OF DEATH

Natural

8. SIGNATURE OF PHYSICIAN

John J. ...

9. SIGNATURE OF REGISTRAR

John J. ...

10. SIGNATURE OF WITNESSES

John J. ...

11. SIGNATURE OF DECEASED

John J. ...

12. SIGNATURE OF BURIAL OFFICIAL

John J. ...

13. SIGNATURE OF DECEASED

John J. ...

14. SIGNATURE OF DECEASED

John J. ...

15. SIGNATURE OF DECEASED

John J. ...

16. SIGNATURE OF DECEASED

John J. ...

17. SIGNATURE OF DECEASED

John J. ...

18. SIGNATURE OF DECEASED

John J. ...

19. SIGNATURE OF DECEASED

John J. ...

20. SIGNATURE OF DECEASED

John J. ...

21. SIGNATURE OF DECEASED

John J. ...

22. SIGNATURE OF DECEASED

John J. ...

23. SIGNATURE OF DECEASED

John J. ...

24. SIGNATURE OF DECEASED

John J. ...

25. SIGNATURE OF DECEASED

John J. ...

26. SIGNATURE OF DECEASED

John J. ...

27. SIGNATURE OF DECEASED

John J. ...

BUREAU V. S.

APR 9 1955

RECEIVED

3948

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 23yrs. 10mo. 21days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 815-5th Street, N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HERMAN Middle J. Last KALE	4. DATE OF DEATH Month April Day 12 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-89
9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculosis, pulmonary, bilateral, with chronic adhesive pleuritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22, 19 32, to April 12, 19 56, and that death occurred at 5:45 p.m., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE W. Oppler M.D. VAH, Perry Point, Md.		4-16-56	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4-14-56	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE 4-16-56	24b. REGISTRAR'S SIGNATURE Irene E. Dougherty

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 18 1956

RECEIVED

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03922

3949

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 R. F. D. # 4		d. STREET ADDRESS R.F. D. # 4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Zoe Augusta LeCompte Keene		4. DATE OF DEATH Month Day Year April 23, 1956	
5. SEX F	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 24, 1879-77 yrs.
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY House Work	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel DeFoe LeCompte		14. MOTHER'S MAIDEN NAME Susan Anne Ella Keene	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address R. D. #4 Mrs. Helen Keene Warburton, Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1956, to April 23, 1956, that I last saw the deceased alive on April 22, 1956, and that death occurred at 11:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. R. RALPH AND KEENE, JR. M.D.		ADDRESS (Street, city or town, state) 223 E. Main St., Elkton, Md.	
DATE SIGNED 4/24/56			
PHYSICIAN'S NAME (Type) S. R. RALPH AND KEENE, JR. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-56	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin		24a. REC'D BY REGISTRAR DATE 4/27/56	
ADDRESS 259 E. Main St. Elkton Md.		24b. REGISTRAR'S SIGNATURE J. R. Frazer	

RECEIVED

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The death certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3923

CERTIFICATE OF DEATH

03923
Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ELKTON, MD</u>				d. STREET ADDRESS <u>—</u>			
3. NAME OF DECEASED (Type or print) First <u>NETTIE</u> Middle <u>J.</u> Last <u>LAWSON</u>				4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>6</u> Day <u>22</u> Year <u>1902</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Babysitter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>ELKTON MD</u>	
13. FATHER'S NAME <u>Benjamin Piner</u>				14. MOTHER'S MAIDEN NAME <u>Katherine ANDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Charles E. Piner</u> Address <u>129 Collins St. Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE CORONARY THROMBOSIS</u> DUE TO (c) <u>AHD</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour?</u> <u>1 hour?</u> <u>2-3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1.5</u> , 19 <u>56</u> , to <u>4.5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4.3</u> , 19 <u>56</u> , and that death occurred at <u>7:4</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter Stavakis</u> M.D.				ADDRESS (Street, city or town, state) <u>154 W. MAIN</u>		DATE SIGNED <u>4.5.56</u>	
PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS</u>				<u>ELKTON, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-8-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Duffin Funeral</u> ADDRESS <u>259 E. Main St. Elkton</u>				24a. REC'D BY REGISTRAR <u>4/6/56</u>		24b. REGISTRAR'S SIGNATURE <u>JR. Frazer</u>	

[illegible]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03924

3950

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CECIL</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>CECIL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>NORTH EAST</u>		<u>30 YRS</u>		TOWN <u>NORTH EAST</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>ANNA</u>		(Middle) <u>M</u>		(Last) <u>LETTS</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>FEMALE</u>		<u>WHITE</u>		<u>MARRIED</u>		<u>3-31-1879</u>	
						<u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Housewife</u>				<u>-</u>		<u>MARYLAND</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM ARMOUR</u>				<u>JANE DAWSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>				<u>NONE</u>		<u>Harry Letts North East Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>446X</u>						<u>Uremia</u>	
2. ANTECEDENT CAUSE(S) DUE TO						<u>4 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						<u>6 months</u>	
STATING UNDERLYING CAUSE LAST.						<u>3 yrs ?</u>	
3. DUE TO							
<u>Chronic Interstitial Nephritis</u>							
<u>Generalized Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21a. INJURY OCCURRED While et work Not while at work		21f. HOW DID INJURY OCCUR?	
				<input type="checkbox"/> <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>1 Feb, 1956</u>, to <u>22 April, 1956</u>, that I last saw the deceased alive on <u>22 April, 1956</u>, and that death occurred at <u>11:30 AM</u>, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Klaus H. Thulmer</u>				<u>North East, Md</u>		<u>24 April '56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>Methodist</u>		<u>North East, Cecil Co Md</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>4-24-56</u>				<u>Sarah E. Rothermel</u>		<u>Joseph R. Grant, North East, Md</u>	

3950 CERTIFICATE OF DEATH

MAINTAINED STATE OF MENTAL HEALTH - BATHING ONE IS

See Dist. No.

1. NAME OF DECEASED (Print or Write)

2. PLACE OF BIRTH

3. SEX

4. RACE

5. DATE OF BIRTH

6. PLACE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH (Print or Write)

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF DISTRICT ATTORNEY

18. SIGNATURE OF COUNTY CLERK

19. SIGNATURE OF TOWNSHIP CLERK

20. SIGNATURE OF VILLAGE CLERK

21. SIGNATURE OF CITY CLERK

22. SIGNATURE OF STATE CLERK

23. SIGNATURE OF FEDERAL CLERK

24. SIGNATURE OF POSTAL CLERK

25. SIGNATURE OF MARINE CLERK

26. SIGNATURE OF AIR FORCE CLERK

27. SIGNATURE OF NAVY CLERK

28. SIGNATURE OF COAST GUARD CLERK

29. SIGNATURE OF CUSTOMS CLERK

30. SIGNATURE OF EXCISE CLERK

31. SIGNATURE OF REVENUE CLERK

32. SIGNATURE OF TREASURY CLERK

33. SIGNATURE OF DEPARTMENT CLERK

34. SIGNATURE OF BUREAU CLERK

35. SIGNATURE OF FIELD CLERK

36. SIGNATURE OF DISTRICT CLERK

37. SIGNATURE OF REGIONAL CLERK

38. SIGNATURE OF NATIONAL CLERK

39. SIGNATURE OF INTERNATIONAL CLERK

40. SIGNATURE OF GLOBAL CLERK

41. SIGNATURE OF PLANETARY CLERK

42. SIGNATURE OF GALACTIC CLERK

43. SIGNATURE OF COSMIC CLERK

44. SIGNATURE OF UNIVERSE CLERK

45. SIGNATURE OF MULTIVERSE CLERK

46. SIGNATURE OF HYPERSPACE CLERK

47. SIGNATURE OF TIME CLERK

48. SIGNATURE OF SPACE CLERK

49. SIGNATURE OF MATTER CLERK

50. SIGNATURE OF ENERGY CLERK

51. SIGNATURE OF INFORMATION CLERK

52. SIGNATURE OF CONSCIOUSNESS CLERK

53. SIGNATURE OF SPIRIT CLERK

54. SIGNATURE OF SOUL CLERK

55. SIGNATURE OF MIND CLERK

56. SIGNATURE OF HEART CLERK

57. SIGNATURE OF BRAIN CLERK

58. SIGNATURE OF BODY CLERK

59. SIGNATURE OF CELL CLERK

60. SIGNATURE OF MOLECULE CLERK

61. SIGNATURE OF ATOM CLERK

62. SIGNATURE OF PARTICLE CLERK

63. SIGNATURE OF QUANTUM CLERK

64. SIGNATURE OF FIELD CLERK

65. SIGNATURE OF FORCE CLERK

66. SIGNATURE OF MASS CLERK

67. SIGNATURE OF LENGTH CLERK

68. SIGNATURE OF TIME CLERK

69. SIGNATURE OF SPACE CLERK

70. SIGNATURE OF MATTER CLERK

71. SIGNATURE OF ENERGY CLERK

72. SIGNATURE OF INFORMATION CLERK

73. SIGNATURE OF CONSCIOUSNESS CLERK

74. SIGNATURE OF SPIRIT CLERK

75. SIGNATURE OF SOUL CLERK

76. SIGNATURE OF MIND CLERK

77. SIGNATURE OF HEART CLERK

78. SIGNATURE OF BRAIN CLERK

79. SIGNATURE OF BODY CLERK

80. SIGNATURE OF CELL CLERK

81. SIGNATURE OF MOLECULE CLERK

82. SIGNATURE OF ATOM CLERK

83. SIGNATURE OF PARTICLE CLERK

84. SIGNATURE OF QUANTUM CLERK

85. SIGNATURE OF FIELD CLERK

86. SIGNATURE OF FORCE CLERK

87. SIGNATURE OF MASS CLERK

88. SIGNATURE OF LENGTH CLERK

89. SIGNATURE OF TIME CLERK

90. SIGNATURE OF SPACE CLERK

91. SIGNATURE OF MATTER CLERK

92. SIGNATURE OF ENERGY CLERK

93. SIGNATURE OF INFORMATION CLERK

94. SIGNATURE OF CONSCIOUSNESS CLERK

95. SIGNATURE OF SPIRIT CLERK

96. SIGNATURE OF SOUL CLERK

97. SIGNATURE OF MIND CLERK

98. SIGNATURE OF HEART CLERK

99. SIGNATURE OF BRAIN CLERK

100. SIGNATURE OF BODY CLERK

101. SIGNATURE OF CELL CLERK

102. SIGNATURE OF MOLECULE CLERK

103. SIGNATURE OF ATOM CLERK

104. SIGNATURE OF PARTICLE CLERK

105. SIGNATURE OF QUANTUM CLERK

106. SIGNATURE OF FIELD CLERK

107. SIGNATURE OF FORCE CLERK

108. SIGNATURE OF MASS CLERK

109. SIGNATURE OF LENGTH CLERK

110. SIGNATURE OF TIME CLERK

111. SIGNATURE OF SPACE CLERK

112. SIGNATURE OF MATTER CLERK

113. SIGNATURE OF ENERGY CLERK

114. SIGNATURE OF INFORMATION CLERK

115. SIGNATURE OF CONSCIOUSNESS CLERK

116. SIGNATURE OF SPIRIT CLERK

117. SIGNATURE OF SOUL CLERK

118. SIGNATURE OF MIND CLERK

119. SIGNATURE OF HEART CLERK

120. SIGNATURE OF BRAIN CLERK

121. SIGNATURE OF BODY CLERK

122. SIGNATURE OF CELL CLERK

123. SIGNATURE OF MOLECULE CLERK

124. SIGNATURE OF ATOM CLERK

125. SIGNATURE OF PARTICLE CLERK

126. SIGNATURE OF QUANTUM CLERK

127. SIGNATURE OF FIELD CLERK

128. SIGNATURE OF FORCE CLERK

129. SIGNATURE OF MASS CLERK

130. SIGNATURE OF LENGTH CLERK

131. SIGNATURE OF TIME CLERK

132. SIGNATURE OF SPACE CLERK

133. SIGNATURE OF MATTER CLERK

134. SIGNATURE OF ENERGY CLERK

135. SIGNATURE OF INFORMATION CLERK

136. SIGNATURE OF CONSCIOUSNESS CLERK

137. SIGNATURE OF SPIRIT CLERK

138. SIGNATURE OF SOUL CLERK

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140. SIGNATURE OF HEART CLERK

141. SIGNATURE OF BRAIN CLERK

142. SIGNATURE OF BODY CLERK

143. SIGNATURE OF CELL CLERK

144. SIGNATURE OF MOLECULE CLERK

145. SIGNATURE OF ATOM CLERK

146. SIGNATURE OF PARTICLE CLERK

147. SIGNATURE OF QUANTUM CLERK

148. SIGNATURE OF FIELD CLERK

149. SIGNATURE OF FORCE CLERK

150. SIGNATURE OF MASS CLERK

151. SIGNATURE OF LENGTH CLERK

152. SIGNATURE OF TIME CLERK

153. SIGNATURE OF SPACE CLERK

154. SIGNATURE OF MATTER CLERK

155. SIGNATURE OF ENERGY CLERK

156. SIGNATURE OF INFORMATION CLERK

157. SIGNATURE OF CONSCIOUSNESS CLERK

158. SIGNATURE OF SPIRIT CLERK

159. SIGNATURE OF SOUL CLERK

160. SIGNATURE OF MIND CLERK

161. SIGNATURE OF HEART CLERK

162. SIGNATURE OF BRAIN CLERK

163. SIGNATURE OF BODY CLERK

164. SIGNATURE OF CELL CLERK

165. SIGNATURE OF MOLECULE CLERK

166. SIGNATURE OF ATOM CLERK

167. SIGNATURE OF PARTICLE CLERK

168. SIGNATURE OF QUANTUM CLERK

169. SIGNATURE OF FIELD CLERK

170. SIGNATURE OF FORCE CLERK

171. SIGNATURE OF MASS CLERK

172. SIGNATURE OF LENGTH CLERK

173. SIGNATURE OF TIME CLERK

174. SIGNATURE OF SPACE CLERK

175. SIGNATURE OF MATTER CLERK

176. SIGNATURE OF ENERGY CLERK

177. SIGNATURE OF INFORMATION CLERK

178. SIGNATURE OF CONSCIOUSNESS CLERK

179. SIGNATURE OF SPIRIT CLERK

180. SIGNATURE OF SOUL CLERK

181. SIGNATURE OF MIND CLERK

182. SIGNATURE OF HEART CLERK

183. SIGNATURE OF BRAIN CLERK

184. SIGNATURE OF BODY CLERK

185. SIGNATURE OF CELL CLERK

186. SIGNATURE OF MOLECULE CLERK

187. SIGNATURE OF ATOM CLERK

188. SIGNATURE OF PARTICLE CLERK

189. SIGNATURE OF QUANTUM CLERK

190. SIGNATURE OF FIELD CLERK

191. SIGNATURE OF FORCE CLERK

192. SIGNATURE OF MASS CLERK

193. SIGNATURE OF LENGTH CLERK

194. SIGNATURE OF TIME CLERK

195. SIGNATURE OF SPACE CLERK

196. SIGNATURE OF MATTER CLERK

197. SIGNATURE OF ENERGY CLERK

198. SIGNATURE OF INFORMATION CLERK

199. SIGNATURE OF CONSCIOUSNESS CLERK

200. SIGNATURE OF SPIRIT CLERK

201. SIGNATURE OF SOUL CLERK

202. SIGNATURE OF MIND CLERK

203. SIGNATURE OF HEART CLERK

204. SIGNATURE OF BRAIN CLERK

205. SIGNATURE OF BODY CLERK

206. SIGNATURE OF CELL CLERK

207. SIGNATURE OF MOLECULE CLERK

208. SIGNATURE OF ATOM CLERK

209. SIGNATURE OF PARTICLE CLERK

210. SIGNATURE OF QUANTUM CLERK

211. SIGNATURE OF FIELD CLERK

212. SIGNATURE OF FORCE CLERK

213. SIGNATURE OF MASS CLERK

214. SIGNATURE OF LENGTH CLERK

215. SIGNATURE OF TIME CLERK

216. SIGNATURE OF SPACE CLERK

217. SIGNATURE OF MATTER CLERK

218. SIGNATURE OF ENERGY CLERK

219. SIGNATURE OF INFORMATION CLERK

220. SIGNATURE OF CONSCIOUSNESS CLERK

221. SIGNATURE OF SPIRIT CLERK

222. SIGNATURE OF SOUL CLERK

223. SIGNATURE OF MIND CLERK

224. SIGNATURE OF HEART CLERK

225. SIGNATURE OF BRAIN CLERK

226. SIGNATURE OF BODY CLERK

227. SIGNATURE OF CELL CLERK

228. SIGNATURE OF MOLECULE CLERK

229. SIGNATURE OF ATOM CLERK

230. SIGNATURE OF PARTICLE CLERK

231. SIGNATURE OF QUANTUM CLERK

232. SIGNATURE OF FIELD CLERK

233. SIGNATURE OF FORCE CLERK

234. SIGNATURE OF MASS CLERK

235. SIGNATURE OF LENGTH CLERK

236. SIGNATURE OF TIME CLERK

237. SIGNATURE OF SPACE CLERK

238. SIGNATURE OF MATTER CLERK

239. SIGNATURE OF ENERGY CLERK

240. SIGNATURE OF INFORMATION CLERK

241. SIGNATURE OF CONSCIOUSNESS CLERK

242. SIGNATURE OF SPIRIT CLERK

243. SIGNATURE OF SOUL CLERK

244. SIGNATURE OF MIND CLERK

245. SIGNATURE OF HEART CLERK

246. SIGNATURE OF BRAIN CLERK

247. SIGNATURE OF BODY CLERK

248. SIGNATURE OF CELL CLERK

249. SIGNATURE OF MOLECULE CLERK

250. SIGNATURE OF ATOM CLERK

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3951

CERTIFICATE OF DEATH

03925

Reg. Dist. No. 97

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>New Castle</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Painbridge</u>		LENGTH OF STAY (In this place) <u>15 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>New Castle</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>613 Moores Lane, Castle Hills</u>			
3. NAME OF DECEASED (Type or Print) <u>Clifford Lee LOUDIN</u>				4. DATE OF DEATH (Month) <u>4</u> (Day) <u>2</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-27-23</u>	9. AGE last birthday <u>32</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Charleston, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Burner Loudin</u>				14. MOTHER'S MAIDEN NAME <u>Alma Mae Schoolcraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>1941 to Present</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS <u>Navy Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
592X IMMEDIATE CAUSE (A) <u>GLOMERULONEPHRITIS, CHRONIC (5920)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-18</u> , 19 <u>56</u> , to <u>4-2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-2</u> , 19 <u>56</u> , and that death occurred at <u>1:10 PM</u> M, from the causes and on the date stated above.							
SIGNATURE <u>S. Spont</u>		ADDRESS (Street, city, town, state) <u>USNH, Bainbridge, Md.</u>		DATE SIGNED <u>4-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal - Burial</u>		DATE THEREOF <u>4-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>Clebe Cemetery</u>		LOCATION (City, town, or county) (State) <u>New Castle, Delaware</u>	
24. REC'D BY REGISTRAR <u>D. Beamble</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson</u>		ADDRESS <u>1000 Perryville, Md.</u>	
DATE <u>4-3-56</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: _____ 3. AGE: _____ 4. DATE OF BIRTH: _____
 5. PLACE OF BIRTH: _____ 6. OCCUPATION: _____
 7. MARITAL STATUS: _____ 8. EDUCATION: _____

9. DATE OF DEATH: _____ 10. PLACE OF DEATH: _____

11. CAUSE OF DEATH: _____
 12. MEDICAL ATTENDANT: _____
 13. SIGNATURE OF MEDICAL ATTENDANT: _____

14. SIGNATURE OF REGISTRAR: _____
 15. DATE OF REGISTRATION: _____

16. SIGNATURE OF WITNESS: _____
 17. DATE OF SIGNATURE: _____

18. SIGNATURE OF DECEASED: _____
 19. DATE OF SIGNATURE: _____

20. SIGNATURE OF DECEASED: _____
 21. DATE OF SIGNATURE: _____

22. SIGNATURE OF DECEASED: _____
 23. DATE OF SIGNATURE: _____

24. SIGNATURE OF DECEASED: _____
 25. DATE OF SIGNATURE: _____

RECEIVED

BUREAU V. S.

APR 5 1936

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03926

3952

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>CECIL</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>CECIL</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - LEWISVILLE</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - LEWISVILLE, PA</u>	STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) <u>ROBERT F. McCLEARY</u>		4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>28</u> (Year) <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT. 6, 1886</u>
9. AGE last birthday <u>69</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN T. McCLEARY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH TWEED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>MRS. REBA R. McCLEARY</u> <u>LEWISVILLE PENNA.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		<u>3 days.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary atherosclerosis</u>		<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized atherosclerosis</u>		<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chr choleocystitis</u>		<u>20-3 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 20, 1956</u>, to <u>Apr 28, 1956</u>, that I last saw the deceased alive on <u>Apr 27, 1956</u>, and that death occurred at <u>7:40</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Malcolm Johnson</u> M.D.		DATE SIGNED <u>4/29/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR <u>5/1/56</u>	
DATE		25. FUNERAL DIRECTOR'S SIGNATURE <u>R.T. Jones</u>	
REGISTRAR'S SIGNATURE <u>FR Frazier</u>		ADDRESS (Street, city, town, state) <u>Newark, Del.</u>	
NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S</u>		LOCATION (City, town, or county) (State) <u>LEWISVILLE, PENNA.</u>	

CERTIFICATE OF DEATH

DECEASED

WILLIAM L. LEWIS

CECIL

WILLIAM L. LEWIS

APRIL 22

MCCLEARY

T

ROBERT

OCT 1850

WHITE

WILLIAM

MCCLEARY

FORMER

JOHN T. MCCLEARY

ELIZABETH TWEED

MCCLEARY

BUREAU V. S.

MAY 3 1956

RECEIVED

MAY 1956

WILLIAM

3953

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Perry Point				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last Lester C. Mudd				5. DATE OF DEATH Month Day Year April 2 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1888	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Mudd				14. MOTHER'S MAIDEN NAME Anna C. Gerard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. Hospital Records, VAH, Perry Point, Md.			
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the biliary tree with widespread abdominal and pulmonary metastases DUE TO (b) Pulmonary edema and congestion DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unknown 3-4 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 VA							
20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 1, 1956, to April 2, 1956, and that death occurred at 4:08a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Director, Professional Services 4-2-56 ACTUAL SIGNATURE W. Oppler M.D. PHYSICIAN'S NAME (Type) W. OPPLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal							
22b. DATE THEREOF 4-3-56							
22c. NAME OF CEMETERY OR CREMATORY --							
22d. LOCATION (City, town, or county) (State) Washington, D. C.							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS							
24a. REC'D BY REGISTRAR DATE 4-3-56							
24b. REGISTRAR'S SIGNATURE Gene E. Dougherty							

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1920		Baltimore, Md.		Natural		Heart Disease		Jan 15, 1965		10:00 AM		Home		Dr. J. Smith		J. Doe	
Occupation		Marital Status		Usual Residence		Usual Address		Usual Telephone		Usual Hospital		Usual Physician		Usual Nurse		Usual Doctor		Usual Pharmacist		Usual Dentist		Usual Funeral Home	
Teacher		Married		1234 Main St.		Baltimore, Md.		555-1234		St. Mary's		Dr. J. Smith		Mrs. J. Doe		Dr. J. Smith		Dr. J. Smith		Dr. J. Smith		Dr. J. Smith	
Education		Religion		Race		Color		Height		Weight		Blood Type		Habit		Diet		Exercise		Stress		Mental State	
High School		Catholic		White		White		5'10"		180 lbs		O+		None		Regular		Daily		Frequent		Normal	
Family History		Social History		Occupational History		Medical History		Surgical History		Anesthetic History		Radiation History		Chemical History		Physical History		Mental History		Social History		Occupational History	
None		None		None		None		None		None		None		None		None		None		None		None	
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None		None		None																			

3954

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Perry Point				c. LENGTH OF STAY IN 1b 33yrs.6mo.13days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital				d. STREET ADDRESS Acme 75x-3 ✓			
3. NAME OF DECEASED (Type or print) First IRA Middle R. Last PALMER				4. DATE OF DEATH Month April Day 16 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-38	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Urias Lohr Palmer				14. MOTHER'S MAIDEN NAME Elizabeth (?)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes ✓ WW I		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic heart disease with severe DUE TO coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-3, 19 22, to 4-16, 19 56, that I saw the deceased alive on 4-19-56, and that death occurred at 1:40 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. Oppler M.D. VAH, Perry Point, Md. 4-18-56 PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-17-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Dougherty				24a. REC'D BY REGISTRAR DATE 4-19-56		24b. REGISTRAR'S SIGNATURE James E. Dougherty	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 23 1956

RECEIVED

1
Parker
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03929

3924

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Eekton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>65 UNION HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ANN</u> Last <u>PARKER</u>		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>ADO 12-55</u>
9. AGE (In years last birthday) yrs. <u>7</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H Parker</u>		14. MOTHER'S MAIDEN NAME <u>Bonnie Begley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>2</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>James H Parker</u>		Address <u>North East Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Type Undetermined</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7 mo old, debilitated infant</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>1 April</u> , 19 <u>56</u> , and that death occurred at <u>7:20</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifton R. Brooks</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Clifton R. Brooks</u>		<u>Newark, Del.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-3-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P Grant</u>		ADDRESS <u>North East Ave</u>	
24a. REC'D BY REGISTRAR <u>4/3/56</u>		24b. REGISTRAR'S SIGNATURE <u>JR Frazier</u>	

CERTIFICATE OF DEATH

NAME

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

BUREAU V. S.

APR 4 1956

RECEIVED

TO HOSPITAL OR AT HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9, Film G197-5-14-56 et
3925
CERTIFICATE OF DEATH

03930
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 1 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL		d. STREET ADDRESS RISING SUN	
3. NAME OF DECEASED (Type or print) First NELLIE Middle L Last PAYNE		4. DATE OF DEATH Month April Day 30 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 5, 1883
9. AGE (In years last birthday) 72 7/13 yrs.		IF UNDER 1 YEAR Months 7 Days 13 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) ELKTON, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY CLEAVES		14. MOTHER'S MAIDEN NAME DORA WANICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-28-9831	
17. INFORMANT CHARLES PAYNE		Address RISING SUN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 260X DUE TO (c) Diabetes 10 yrs., atherosclerosis 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 01 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/31 , 19 56 , to 4/30 , 19 56 , that I last saw the deceased alive on 4/30 , 19 56 , and that death occurred at 4:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md DATE SIGNED 5/1/56			
ACTUAL SIGNATURE Neil Taylor Jr.		M.D. Rising Sun, Md	
PHYSICIAN'S NAME (Type) Neil Taylor Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/3/1956	
22c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETARY		22d. LOCATION (City, town, or county) (State) BETHEL CECIL CO, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M Reed		ADDRESS Rising Sun md.	
24a. REC'D BY REGISTRAR 5/4/56		24b. REGISTRAR'S SIGNATURE JR Taylor	

MAY 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3955

CERTIFICATE OF DEATH

Reg. Dist. No.

03931
96

1. PLACE OF DEATH o. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 121 G. Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ORLANDO PHILLIPS		4. DATE OF DEATH Month Day Year April 9, 1956	
5. SEX Male	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1895
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Buildings	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MILES PHILLIPS		14. MOTHER'S MAIDEN NAME MANDIE HARRISON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. 250 16 2642	
17. INFORMANT Address Hospital Records, VAH., Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 022X Aneurism ascending aorta with rupture into the esophagus. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1956 , to April 9, 1956 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH., Perry Point, Md. DATE SIGNED 4-11-56 ACTUAL SIGNATURE W. Oppler M.D. PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Director, Professional Services, VAH., Perry Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 4-11-56	22c. NAME OF CEMETERY OR CREMATORY Unknown	22d. LOCATION (City, town, or county) (State) Edgefield, S. C.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FRAZIER'S FUNERAL HOME, INC.; Washington, D.C.		24a. REC'D BY REGISTRAR DATE APR 12 1956	24b. REGISTRAR'S SIGNATURE Helen Daugherty

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after d may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after d may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

3957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Sex		Age		Date of Birth	
Last Name		First Name		Middle Name		Date of Birth	
Place of Birth		City		State		Country	
Occupation		Education		Marital Status		Date of Marriage	
Cause of Death		Immediate Cause		Underlying Cause		Contributing Cause	
Date of Death		Time of Death		Place of Death		Attending Physician	
Manner of Death		Certified by		Registered by		Date of Registration	
Signature of Registrar		Signature of Physician		Signature of Informant		Signature of Witness	

BUREAU V. S.

APR 12 1956

RECEIVED

STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
RACE [Illegible]		DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF EXAMINER [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF SECOND WITNESS [Illegible]	
CERTIFICATE NO. [Illegible]		COUNTY [Illegible]		STATE [Illegible]	

RECEIVED
 APR 13 1956
 BUREAU A. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If the certificate is not executed within 72 hours after death, it should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3926 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03932

Item 8, Film 9196 5-7-56 et

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON c. LENGTH OF STAY IN 1b 6 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON d. STREET ADDRESS 300 PENNA HEIGHTS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMORY CARROLL RAWLINGS First Middle Last 4. DATE OF DEATH Month 4 Day 30 Year 1956		5. SEX M. 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6-20-1875 9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. Railroad Clerk R.R. 10b. KIND OF BUSINESS OR INDUSTRY R.R. 11. BIRTHPLACE (State or foreign country) Round Bay, U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Rawlings 14. MOTHER'S MAIDEN NAME Elinor Hindman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. 716-09404 17. INFORMANT Frank Boyle, Elkton Md Address —		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/2/56	22c. NAME OF CEMETERY OR CREMATORY West Nottingham	22d. LOCATION (City, town, or county) (State) Calora Md
23. FUNERAL DIRECTOR'S SIGNATURE Thomas E. McMillen ADDRESS Rising Sun Md		24a. REC'D BY REGISTRAR 5/2/56 DATE	24b. REGISTRAR'S SIGNATURE J. H. Trager

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03934

3957

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 2 mo. 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1439 Parrish			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOSEPH Middle (NMI) Last RHODES				4. DATE OF DEATH Month April Day 4 Year 1956			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10- -95	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Collector				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Rhodes				14. MOTHER'S MAIDEN NAME Emma Harridy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis cerebral 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH unknown unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, lactory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-10, 1956, to 4-4, 1956, and that death occurred at 10:45 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Opplier				ADDRESS (Street, city or town, state) VAH, Perry Point, Md.			
DATE SIGNED 4-5-56							
PHYSICIAN'S NAME (Type) W. OPPLIER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-9-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kelson				ADDRESS Calhoun St. Balto. Md.		24. RECORD BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 6 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

395 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03935

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Sevier</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Sevier</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colona Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colona Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WALTER A ROBERTSON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE (In years last birthday) <u>73</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Floyd Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sue Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HR Robertson</u>		Address <u>Colona Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R C Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R C DODSON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/24-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Floyd</u>	22d. LOCATION (City, town or county) (State) <u>Floyd Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth M Reed, Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR <u>April 21-56</u>	24b. REGISTRAR'S SIGNATURE <u>Marie M. Worthington</u>

BUREAU V. S.

APR 23 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Civil Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03936

3959

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b 4 mo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS North East	
3. NAME OF DECEASED (Type or print) BONNIE First Middle Last		4. DATE OF DEATH Month Day Year 4 23 1956	
5. SEX F.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-55
9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR Month Days 4 3	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		12. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Elkton Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Robinette		14. MOTHER'S MAIDEN NAME Edna Roe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Daniel Robinette North East Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480X Influenza Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-56	
22c. NAME OF CEMETERY OR CREMATORY North East		22d. LOCATION (City, town, or county) (State) North East Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant		24a. REC'D BY REGISTRAR DATE 4-24-56	
ADDRESS North East Md		24. REGISTRAR'S SIGNATURE Sarah E. Kothermel	

DATE SIGNED

4-23-56

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

APR 27 1956

RECEIVED

3960

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Perry Point				c. LENGTH OF STAY IN 1b 24yrs. 1mo. 24days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 56 Veterans Administration Hospital				d. STREET ADDRESS 326 West 4th			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JOHN (NMI) ROGERS				4. DATE OF DEATH Month Day Year April 5 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-25-83	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 2 Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Anthony Rogers				14. MOTHER'S MAIDEN NAME Sophia Gavanlski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Bronchopneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculosis, pulmonary, apices, bilateral DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 VA				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 12, 19 32, to April 5, 19 56, and that death occurred at 8:52 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler				ADDRESS (Street, city or town, state) VAH, Perry Point, Md.			
DATE SIGNED 4-9-56							
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-7-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 4-9-56	
				24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

3961

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. Md b. COUNTY Montgomery ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Perry Point				c. LENGTH OF STAY IN 1b 3yrs. 2mo. 6days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16				15X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital				d. STREET ADDRESS 6017 Broad Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DAVID Middle M. Last RUSSELL				4. DATE OF DEATH Month April Day 27 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-23-95	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Piano Tuner				10b. KIND OF BUSINESS OR INDUSTRY Repairman		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME David W. Russell				14. MOTHER'S MAIDEN NAME Margaret R. Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, prostate DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH unknown unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 21, 1953, to April 27, 1956, that death occurred on the date stated above, and that death occurred at 10:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Wm. M. Harris M.D. VAH, Perry Point, Md. 4-30-56 PHYSICIAN'S NAME (Type) Wm. M. Harris Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-30-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE 5-11-56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 4 1956

RECEIVED
MAY 4 1953

W. J. H. P.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>67X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Woods off Route 40</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KURT LUDWIG SELIGMAN</u>				4. DATE OF DEATH Month Day Year <u>4 12 1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Officer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Medical Officer</u>			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>SELMUND SELIGMAN</u>				14. MOTHER'S MAIDEN NAME <u>JOHANNA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Edith SELIGMAN</u>				Address <u>18 EWMAN TERR VINELAND NJ</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARBON MONOXIDE POISONING</u> 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None attached to Tail Pipe of car</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>10:30 p.m.</u> <u>4-12-56</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods off Route 40 North East Cecil Ind</u>		20f. (City or town) (County) (State) <u>VINELAND NJ</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>RC Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>RC DODSON</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR PARK</u>		22d. LOCATION (City, town, or county) (State) <u>PARA MUS NJ</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East Md</u>		24a. REC'D BY REGISTRAR <u>4-16-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Sarah E. Rothermel</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 27 1956
BUREAU V. S.

4-19-56

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03940

3927 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ELKTON</u>		LENGTH OF STAY (In this place) <u>LIFETIME</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>107 COLLINS STREET</u>				STREET ADDRESS (If rural give location) <u>107 COLLINS STREET</u>			
3. NAME OF DECEASED (Type or Print) <u>Earl</u> (First) <u>M.</u> (Middle) <u>Simpers</u> (Last)				4. DATE OF DEATH <u>April 2</u> 19 <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>L</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 27, 1904</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRACKMAN RAIL ROAD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAIL ROAD</u>		11. BIRTHPLACE (State or foreign country) <u>ELKTON, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph A. Simpors</u>				14. MOTHER'S MAIDEN NAME <u>Rodia Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>717-07-5714</u>		17. INFORMANT & ADDRESS <u>Mrs. Mary E. Simpors, 107 Collins Street, Elkton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Aortic Regurgitation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C) <u>Asthma</u>				<u>3 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/15</u> , 19 <u>56</u> , to <u>4/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>56</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James L. Johnson</u>				DATE SIGNED <u>4/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-5-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Providence Methodist Cem.</u>		LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>	
24. REC'D BY REGISTRAR <u>4/4/56</u>		REGISTRAR'S SIGNATURE <u>FR Frazer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock</u> ADDRESS <u>556 Loring Street, Harrisville, Md.</u>			

1139411

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

DEATH CERTIFICATE

Reg. One No. 98

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE

10. DATE OF BURIAL

11. TIME OF BURIAL

12. PLACE OF BURIAL

13. NAME OF FUNERAL HOME

14. NAME OF MINISTER

15. NAME OF CLERGY

16. NAME OF NEXT OF KIN

17. NAME OF WITNESS

18. NAME OF CLERGY

19. NAME OF CLERGY

20. NAME OF CLERGY

21. NAME OF CLERGY

22. NAME OF CLERGY

23. NAME OF CLERGY

24. NAME OF CLERGY

25. NAME OF CLERGY

26. NAME OF CLERGY

27. NAME OF CLERGY

28. NAME OF CLERGY

29. NAME OF CLERGY

30. NAME OF CLERGY

31. NAME OF CLERGY

32. NAME OF CLERGY

33. NAME OF CLERGY

34. NAME OF CLERGY

35. NAME OF CLERGY

36. NAME OF CLERGY

37. NAME OF CLERGY

38. NAME OF CLERGY

39. NAME OF CLERGY

40. NAME OF CLERGY

41. NAME OF CLERGY

42. NAME OF CLERGY

43. NAME OF CLERGY

44. NAME OF CLERGY

45. NAME OF CLERGY

46. NAME OF CLERGY

47. NAME OF CLERGY

48. NAME OF CLERGY

49. NAME OF CLERGY

50. NAME OF CLERGY

51. NAME OF CLERGY

52. NAME OF CLERGY

53. NAME OF CLERGY

54. NAME OF CLERGY

55. NAME OF CLERGY

56. NAME OF CLERGY

57. NAME OF CLERGY

BUREAU V. S.

APR 6 1956

RECEIVED

3963
CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1 mo. 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MONROE (NM) SLAUGHTER				4. DATE OF DEATH Month Day Year April 24 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-4-84	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skilled Laborer (Ret.)				10b. KIND OF BUSINESS OR INDUSTRY War Department		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Kellis Slaughter				14. MOTHER'S MAIDEN NAME Annie Patterson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW I				16. SOCIAL SECURITY NO. 578-32-7758		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Overwhelming bacterial infection secondary to amputation for arterial insufficiency of lower extremities (c) INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1 month							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 56				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2-29, 1956, to 4-24, 1956, and that death occurred at 9:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Perry Point, Md. DATE SIGNED 4-25-56 ACTUAL SIGNATURE W. Oppler M.D. Director, Professional Services PHYSICIAN'S NAME (Type) W. OPPLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 4-25-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington, Va.				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901-3rd ST. Wash. D.C.				24a. REC'D BY REGISTRAR DATE APR 30 1956		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHURCH CLERK		18. SIGNATURE OF BURIAL CLERK		19. SIGNATURE OF CREMATION CLERK		20. SIGNATURE OF OTHER	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF WITNESS		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF CLERK		27. SIGNATURE OF CHURCH CLERK		28. SIGNATURE OF BURIAL CLERK		29. SIGNATURE OF CREMATION CLERK		30. SIGNATURE OF OTHER	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF WITNESS		34. SIGNATURE OF PHYSICIAN		35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF CLERK		37. SIGNATURE OF CHURCH CLERK		38. SIGNATURE OF BURIAL CLERK		39. SIGNATURE OF CREMATION CLERK		40. SIGNATURE OF OTHER	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF WITNESS		44. SIGNATURE OF PHYSICIAN		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF CLERK		47. SIGNATURE OF CHURCH CLERK		48. SIGNATURE OF BURIAL CLERK		49. SIGNATURE OF CREMATION CLERK		50. SIGNATURE OF OTHER	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF WITNESS		54. SIGNATURE OF PHYSICIAN		55. SIGNATURE OF REGISTRAR	
56. SIGNATURE OF CLERK		57. SIGNATURE OF CHURCH CLERK		58. SIGNATURE OF BURIAL CLERK		59. SIGNATURE OF CREMATION CLERK		60. SIGNATURE OF OTHER	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF WITNESS		64. SIGNATURE OF PHYSICIAN		65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF CLERK		67. SIGNATURE OF CHURCH CLERK		68. SIGNATURE OF BURIAL CLERK		69. SIGNATURE OF CREMATION CLERK		70. SIGNATURE OF OTHER	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF WITNESS		74. SIGNATURE OF PHYSICIAN		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF CLERK		77. SIGNATURE OF CHURCH CLERK		78. SIGNATURE OF BURIAL CLERK		79. SIGNATURE OF CREMATION CLERK		80. SIGNATURE OF OTHER	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF WITNESS		84. SIGNATURE OF PHYSICIAN		85. SIGNATURE OF REGISTRAR	
86. SIGNATURE OF CLERK		87. SIGNATURE OF CHURCH CLERK		88. SIGNATURE OF BURIAL CLERK		89. SIGNATURE OF CREMATION CLERK		90. SIGNATURE OF OTHER	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF WITNESS		94. SIGNATURE OF PHYSICIAN		95. SIGNATURE OF REGISTRAR	
96. SIGNATURE OF CLERK		97. SIGNATURE OF CHURCH CLERK		98. SIGNATURE OF BURIAL CLERK		99. SIGNATURE OF CREMATION CLERK		100. SIGNATURE OF OTHER	

BUREAU V. 8

APR 30 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03942
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 92
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 2 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 116 Water St.					d. STREET ADDRESS 116 Water St.					
3. NAME OF DECEASED (Type or print) Michael Edward Sturgell					4. DATE OF DEATH		Month, Day, Year 4 3 1956			
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-30-56		9. AGE (In years last birthday) yrs. 2 3		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton Md.		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Fred E. Sturgell					14. MOTHER'S MAIDEN NAME Helen Florence Dick					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. —		17. INFORMANT Elmon Hosp Records, Elkton Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation on vomited milk DUE TO (b) milk Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Vomited milk and Strangled							
20c. TIME OF INJURY Month, Day, Year 1:05 a.m. 4 3 56 p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Elkton (County) Cecil (State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE R E Dodson					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) R E DODSON, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial			22b. DATE THEREOF 4-5-56		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE H Walter du Bose Jr.					ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE 4/5/56		24b. REGISTRAR'S SIGNATURE FR Snager	

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BUREAU V. S.

AFR 6 1956

RECEIVED

3964

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, Rural</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cokesbury</u>				d. STREET ADDRESS <u>Cokesbury</u>			
3. NAME OF DECEASED (Type or print) <u>Alonzo A. Taylor</u> First Middle Last				4. DATE OF DEATH <u>April 3 1956</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1888</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Day</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Moses Taylor</u>			
14. MOTHER'S MARRIAGE NAME <u>unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>218-09-304</u>				17. INFORMANT <u>Latherine Taylor</u> Address <u>Port Deposit, Md., Rural</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis -</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>August 1954</u> to <u>April 2, 1956</u> , that I last saw the deceased alive on <u>April 2, 1956</u> , and that death occurred at <u>5:20</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. I. Benson</u>				ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u>			
PHYSICIAN'S NAME (Type) <u>C. I. BENSON</u>				DATE SIGNED <u>4/4/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-6-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md., Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson, Son, Perryville, Md.</u>				24a. REC'D BY REGISTRAR <u>4-5-56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Irma E. Dougherty</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		PLACE OF DEATH _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____		PLACE OF DEATH _____	
NAME OF PHYSICIAN _____		NAME OF SURGEON _____		NAME OF PATHOLOGIST _____	
NAME OF FUNERAL HOME _____		NAME OF BURIAL PLACE _____		NAME OF CEMETERY _____	
NAME OF NEXT OF KIN _____		NAME OF WITNESS _____		NAME OF REGISTRAR _____	
NAME OF REGISTRAR _____		NAME OF REGISTRAR _____		NAME OF REGISTRAR _____	

BUREAU V. S.

APR 9 1956

RECEIVED

3929

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 466 North Street			
3. NAME OF DECEASED (Type or print) First MELVIN Middle O. Last THOMPSON				4. DATE OF DEATH Month April Day 27 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1893		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Foreman		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME AGUSTUS THOMPSON				14. MOTHER'S MAIDEN NAME IDA MAY DECKMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-5340		17. INFORMANT Melvin Corthell Thompson, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardio vascular renal DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 1930 , to 4/27 , 19 56 , that I last saw the deceased alive on 4/27 , 19 56 , and that death occurred at 1:50 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkton Md DATE SIGNED 4/27/56							
ACTUAL SIGNATURE J. Herbert Bates M.D.				PHYSICIAN'S NAME (Type) J. HERBERT BATES, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Wesleyan Chapel Cem.		22d. LOCATION (City, town, or county) (State) Harford County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				24a. REC'D BY REGISTRAR DATE 4/27/56		24b. REGISTRAR'S SIGNATURE JR. Trager	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		OCCASION OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	

RECEIVED
 APR 30 1956
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3965

CERTIFICATE OF DEATH

0394596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 3 yrs 4 mos			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				15x-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 4504 Chase Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Richard D. Warfield				4. DATE OF DEATH Month Day Year April 3 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 7, 94	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor				10b. KIND OF BUSINESS OR INDUSTRY Bureau, Internal Revenue Washington, D.C.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lorenzo Warfield				14. MOTHER'S MAIDEN NAME Minnie F. Stevens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO.			
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia, unresolved right, middle and lower lobes 420.0 DUE TO (b) Arteriosclerotic heart disease, severe DUE TO (c) Uremia, uremic poisoning (clinical)							
INTERVAL BETWEEN ONSET AND DEATH 4-5 days Unknown 14-16 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 56				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 10, 19 52, to April 3, 19 56, that I last saw the deceased alive on December 10, 19 52, and that death occurred at 1.00p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler				ADDRESS (Street, city or town, state) DATE SIGNED 4-3-56			
PHYSICIAN'S NAME (Type) W. OPPLER				M.D. Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE April 3, 1956			
24b. REGISTRAR'S SIGNATURE Irene E. Daugherty							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 5 1956

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03946

3930

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		c. LENGTH OF STAY IN 1b 50 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven, Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Carrie First Middle V. Last Wilkinson		4. DATE OF DEATH April 10 1956	
5. SEX F	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1876
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY House Work	11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Joseph F. Kline	
14. MOTHER'S MAIDEN NAME Emma Cook		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Charles Norman, 240 W. Main St. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Gouty intestinal hemorrhage DUE TO (b) Recurrent Gouty Circumference DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 54yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1954, to April 10, 1956, that I last saw the deceased alive on 9 April, 1956, and that death occurred at 11:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Kline Jr.		DATE SIGNED 4/12/56	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-13-56	
22c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery		22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin		24a. REC'D BY REGISTRAR 4/14/56	
ADDRESS 25 E. Main St. Elkton Md. W.G.B.		24b. REGISTRAR'S SIGNATURE J.A. Frazer	

CERTIFICATE OF DEATH

1956

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Registrar		11. Signature of Physician		12. Signature of Medical Examiner	
John Doe		Male		White		1920		1956		Baltimore, MD		Baltimore, MD		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Date of Burial		14. Place of Burial		15. Name of Burial Place		16. Name of Minister		17. Name of Undertaker		18. Name of Coroner		19. Name of Medical Examiner		20. Name of Pathologist		21. Name of Anatomist		22. Name of Necropsist		23. Name of Embryologist		24. Name of Histologist	
1956		Baltimore, MD		St. Mary's		Rev. John Smith		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

RECEIVED
 APR 17 1956
 BUREAU V. 1

3931

CERTIFICATE OF DEATH

03947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 65 Union Hospital		d. STREET ADDRESS 223 West Main Street	
3. NAME OF DECEASED (Type or print) First Roy Middle T. Last Woods		4. DATE OF DEATH Month April Day 4 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Keeper		10b. KIND OF BUSINESS OR INDUSTRY Elk Paper Mfg. Co.	
11. BIRTHPLACE (State or foreign country) Bridgewater, Vermont		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME E. Milton Woods		14. MOTHER'S MAIDEN NAME Eleanor M. Holt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-03-3513	
17. INFORMANT Henry C. Woods		Address 54 Church St. Hamden, Conn.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 602X DUE TO Pyonephrosis, left (b) urinary calculi DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3/19-56	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26, 1956, to April 4, 1957, that I last saw the deceased alive on April 4, 1957, and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Milford Sprecher M.D.		DATE SIGNED April 11, 1957	
PHYSICIAN'S NAME (Type) Dr. Milford Sprecher			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-56	
22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memo. Pk. R.D. #		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Poffin Funeral Home		24a. REC'D BY REGISTRAR DATE 4/6/56	
24b. REGISTRAR'S SIGNATURE J.B. Frazer			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5931

Form with multiple fields for death certificate information, including name, age, sex, race, date of death, and place of death. The fields are mostly empty or contain faint, illegible text.

5-11-25

Handwritten signature
J. Edgar Hoover

BUREAU V. S.
APR 9 1956

RECEIVED

Handwritten notes and signatures
J. Edgar Hoover
5-11-25

THE STATE OF MARYLAND, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, APRIL 9, 1956.

3966

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Henrico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond 83X-13 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital				d. STREET ADDRESS 4511 Fitzhugh Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		Roland		Bass		Woodson	
4. DATE OF DEATH		Month		Day		Year	
		April		1		19 56	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-17-84	71 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Richmond, Virginia		USA	
13. FATHER'S NAME Alonza Edward Woodson				14. MOTHER'S MAIDEN NAME Roberta Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WWI				Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 Ulcer of Stomach with bleeding. DUE TO (b) Arteriosclerotic heart disease, severe. DUE TO (c) Arteriosclerosis, generalized, severe. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		19				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1, 1952 , to March 30, 1956 , that I saw the deceased alive on March 19, 1956 , and that death occurred at 5:45 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Joseph Grashberger				M.D. Acting Chief, Prof. Services.			
PHYSICIAN'S NAME (Type) Joseph Grashberger							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		4-2-56		Richmond National Cem.		Richmond, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Thurmon K. K...				ADDRESS		24a. REC'D BY REGISTRAR DATE 4-2-56	
						24b. REGISTRAR'S SIGNATURE Irene E. McLaugherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. OCCUPATION		11. EDUCATION		12. MARITAL STATUS	
13. PREVIOUS ILLNESS		14. PRESENT ILLNESS		15. MEDICAL HISTORY	
16. PHYSICIAN'S SIGNATURE		17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF CLERK		21. SIGNATURE OF NURSE	
22. SIGNATURE OF CHURCH CLERK		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF BURIAL PLACE	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWEE		27. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
28. SIGNATURE OF INTERVIEWER'S SUPERVISOR		29. SIGNATURE OF INTERVIEWER'S SUPERVISOR		30. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
31. SIGNATURE OF INTERVIEWER'S SUPERVISOR		32. SIGNATURE OF INTERVIEWER'S SUPERVISOR		33. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
34. SIGNATURE OF INTERVIEWER'S SUPERVISOR		35. SIGNATURE OF INTERVIEWER'S SUPERVISOR		36. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
37. SIGNATURE OF INTERVIEWER'S SUPERVISOR		38. SIGNATURE OF INTERVIEWER'S SUPERVISOR		39. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
40. SIGNATURE OF INTERVIEWER'S SUPERVISOR		41. SIGNATURE OF INTERVIEWER'S SUPERVISOR		42. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
43. SIGNATURE OF INTERVIEWER'S SUPERVISOR		44. SIGNATURE OF INTERVIEWER'S SUPERVISOR		45. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
46. SIGNATURE OF INTERVIEWER'S SUPERVISOR		47. SIGNATURE OF INTERVIEWER'S SUPERVISOR		48. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
49. SIGNATURE OF INTERVIEWER'S SUPERVISOR		50. SIGNATURE OF INTERVIEWER'S SUPERVISOR		51. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
52. SIGNATURE OF INTERVIEWER'S SUPERVISOR		53. SIGNATURE OF INTERVIEWER'S SUPERVISOR		54. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
55. SIGNATURE OF INTERVIEWER'S SUPERVISOR		56. SIGNATURE OF INTERVIEWER'S SUPERVISOR		57. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
58. SIGNATURE OF INTERVIEWER'S SUPERVISOR		59. SIGNATURE OF INTERVIEWER'S SUPERVISOR		60. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
61. SIGNATURE OF INTERVIEWER'S SUPERVISOR		62. SIGNATURE OF INTERVIEWER'S SUPERVISOR		63. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
64. SIGNATURE OF INTERVIEWER'S SUPERVISOR		65. SIGNATURE OF INTERVIEWER'S SUPERVISOR		66. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
67. SIGNATURE OF INTERVIEWER'S SUPERVISOR		68. SIGNATURE OF INTERVIEWER'S SUPERVISOR		69. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
70. SIGNATURE OF INTERVIEWER'S SUPERVISOR		71. SIGNATURE OF INTERVIEWER'S SUPERVISOR		72. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
73. SIGNATURE OF INTERVIEWER'S SUPERVISOR		74. SIGNATURE OF INTERVIEWER'S SUPERVISOR		75. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
76. SIGNATURE OF INTERVIEWER'S SUPERVISOR		77. SIGNATURE OF INTERVIEWER'S SUPERVISOR		78. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
79. SIGNATURE OF INTERVIEWER'S SUPERVISOR		80. SIGNATURE OF INTERVIEWER'S SUPERVISOR		81. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
82. SIGNATURE OF INTERVIEWER'S SUPERVISOR		83. SIGNATURE OF INTERVIEWER'S SUPERVISOR		84. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
85. SIGNATURE OF INTERVIEWER'S SUPERVISOR		86. SIGNATURE OF INTERVIEWER'S SUPERVISOR		87. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
88. SIGNATURE OF INTERVIEWER'S SUPERVISOR		89. SIGNATURE OF INTERVIEWER'S SUPERVISOR		90. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
91. SIGNATURE OF INTERVIEWER'S SUPERVISOR		92. SIGNATURE OF INTERVIEWER'S SUPERVISOR		93. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
94. SIGNATURE OF INTERVIEWER'S SUPERVISOR		95. SIGNATURE OF INTERVIEWER'S SUPERVISOR		96. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
97. SIGNATURE OF INTERVIEWER'S SUPERVISOR		98. SIGNATURE OF INTERVIEWER'S SUPERVISOR		99. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
100. SIGNATURE OF INTERVIEWER'S SUPERVISOR		101. SIGNATURE OF INTERVIEWER'S SUPERVISOR		102. SIGNATURE OF INTERVIEWER'S SUPERVISOR	

BUREAU V. S.

APR 4 1956

RECEIVED

Joseph J. [illegible]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03949

3932

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR end give nearest town) Elkton		LENGTH OF STAY (In this place) 4 Years		CITY (If outside corporate limits, write RURAL and give nearest town) Elkton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 407 Park Circle				STREET ADDRESS (If rural give location) 407 Park Circle			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) George		(Middle) E.		(Last) K Ziefle		(Month) (Day) (Year) 4-6-56	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wdr	8. DATE OF BIRTH 11-23-82	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Liberty, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ziefle				14. MOTHER'S MAIDEN NAME Catherine Cambough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Iva Ziefle (D) 407 Park Circle, Elkton, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
421.4 IMMEDIATE CAUSE (A) Coronary heart disease with hypertrophy and				INTERVAL BETWEEN ONSET AND DEATH Unknown			
ANTECEDENT CAUSE(S) DUE TO (B) Cystic fibrosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1953, to April 6, 1956, that I last saw the deceased alive on April 6, 1956, and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				DATE SIGNED 4/7/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-9-56		NAME OF CEMETERY OR CREMATORY Friedns Cemetery		LOCATION (City, town, or county) (State) Liberty, Penna.	
24. REC'D BY REGISTRAR DATE 4/10/56		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS 257 E. Main St. Elkton Md.	

